

## FUNCTIONAL ANALYTIC REHABILITATION: A CONTEXTUAL BEHAVIORAL APPROACH TO CHRONIC DISTRESS

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The chronic distress many consumers experience may be a result of perpetuating factors associated with lifestyle rather than with the signs and symptoms associated with a formal diagnosis. Frequently, these individuals require a highly structured treatment environment to maximize contact with the contingencies associated with effective illness management and social skills. Functional Analytic Rehabilitation (FAR) is a behavioral approach which keeps consumers in contact with relevant contextual factors as they participate in traditional curriculum-based interventions (e.g., UCLA and DBT skills training). Thus, the program is organized with the goal of creating a functional similarity with real-life environments. As a result, behavioral momentum is developed to maintain social effectiveness and to overcome the numerous disincentives to participating in community-based activities.

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The present paper outlines a treatment approach, Functional Analytic Rehabilitation (FAR), which creates a treatment context in which persons who experience chronic distress learn to cope more efficiently in social settings. The term "chronic distress" refers to a state in which individuals, in response to psychiatric symptoms, create lifestyles that inadvertently perpetuate and even amplify their problems. These persons often develop an inflexible and ineffective interpersonal style, marked by the avoidance of aversive emotional states, which they apply across multiple social roles and situations. The short-term relief from aversive emotional states via experiential avoidance (Hayes, Strosahl, & Wilson, 1999; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996) obscures the aversive but slow and cumulative consequences.

Individuals experiencing chronic distress can be found across numerous diagnostic categories. In fact, this condition is better understood from the contextual perspective than that of a formal psychiatric diagnosis (Hayes & Follette, 1992).

Traditional day-treatment approaches to rehabilitation tend to have limited benefits for persons experiencing chronic distress (e.g., Linehan, 1993). Most such programs tend to

focus on manualized topographical skills training and less so on the contextual factors associated with the expression of a particular illness. Despite efforts to promote the generalization of newly acquired skills via the use of homework exercises and joint planning with ancillary workers and/or family members, minimal direct intervention occurs within relevant contexts (e.g., in the residential facility, home; Heinssen, Liberman, & Kopelowicz, 2000).

Manual-based treatments generally follow a specified sequential outline in order to increase treatment fidelity. In contrast, principle-based interventions have more flexibility because they are able to respond to particular consumer needs in the moment (Miller & Rathus, 2000). FAR takes into account the contextual factors (i.e., discriminative, eliciting and reinforcing stimuli) relevant to skills acquisition and generalization, combining the strengths of both manual-based and principle-based interventions in order to promote effective living for multi-problem, treatment-refractory consumers. It thus attempts to provide a functionally relevant context for optimizing manual-based therapies (e.g., UCLA skills training modules) using principle-based interventions. FAR draws heavily upon radical behavioral assumptions and in particular, applies principles of Functional Analytical Psychotherapy (FAP; Kohlenberg, Hayes &

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Tsai, 1993; Kohlenberg and Tsai, 1991; Hayes, Kohlenberg, & Melancon, 1989) to the broader context of the rehabilitation treatment milieu. FAR has been extended to conditions as diverse as schizophrenia, borderline personality disorder, and recurrent major depression.

## THEORETICAL ASSUMPTIONS

### Fundamental Components of FAP

A brief overview of FAP will serve to familiarize the reader with concepts used in FAR. FAP is a radical behavior psychotherapy that focuses on the moment-to-moment interactions between the therapist and the consumer occurring in the therapy room. FAP therapists track verbal behavior (Skinner, 1957) in order to identify clinically relevant behaviors. Consumer verbalizations about events occurring either outside or inside the office are always considered in light of their implications for the ongoing relationship between therapist and consumer.

The concept of Clinically Relevant Behaviors (CRBs) is central to an understanding of FAP. Kohlenberg and Tsai (1991) outline three types of CRBs: a CRB1 is an ineffective behavior that interferes with successful living; a CRB2 is an effective behavioral alternative that leads to increased success in living; and a CRB3 is a behavioral interpretation of the context of a behavior. The FAP therapist basically serves three functions in the therapy session, that of a discriminative, an eliciting and a reinforcing stimulus. The therapist acts as an eliciting stimulus of consumer respondent behavior, a discriminative stimulus for operant behavior, and a reinforcing stimulus for effective behavior. In serving these functions, Kohlenberg and Tsai have outlined five tasks that increase the likelihood that a therapist will effectively influence consumer behaviors: She is to be vigilant to CRB1s; create an interpersonal context that will evoke CRBs; reinforce instances of CRB2s; be aware of the relationship between therapist behavior and CRBs; and, finally, interpret controlling variables that influence consumer behavior.

### Theoretical Assumptions of Contextual Behaviorism

FAR is grounded in many of the assumptions associated with both radical and contextual behaviorism (Kohlenberg & Tsai,

1991; Skinner, 1957; Hayes, 1991). It assumes that all behavior, whether public or private (e.g., thoughts), has its origins in the environment. The contingencies associated with these behaviors are assumed to shape as well as to maintain their occurrence.

From a FAR perspective, behavior is best understood via a description of the context in which it occurs, including both its setting and consequences (Hayes, 1991). These contextual factors may be either public or private. They may also be either immediate or remote in time. Behavior is most effectively influenced when the contextual factors associated with its performance are present. Thus, in the rehabilitation setting, when target behaviors are present, the treatment team assumes that the current situation possesses a functional similarity to an individual's natural environment. That is, the discriminative and/or eliciting stimuli for identified problem behaviors occurring in natural settings are assumed to be present in the treatment context. At the moment that the problem behavior occurs, the treatment milieu shares features with the person's real-life situation. The treatment team conceptualizes behavior in the milieu using explanations or interpretations that involve a description of the □controlling variables□ of target behavior. These variables consist of the public and/or private, remote and/or immediate events that exert influence on current behavior (Kohlenberg & Tsai, 1991).

### FAR: RATIONALE

Persons who experience chronic distress behave in ways that are functional in their current environments but that tend to perpetuate their individual malaise (Hayes, 1999). Influencing change requires a highly structured environment that keeps the individual in contact with contingencies that reinforce effective living. Weekly psychotherapy may not provide adequate behavioral momentum for effective behaviors to endure in natural settings (Linehan, 1993). Functional Analytic Rehabilitation creates a context within which traditional manualized skills training treatment strategies (e.g., Psychosocial Rehabilitation [PSR], Dialectic Behavior Therapy [DBT]) can work more successfully for chronically distressed persons. Traditional rehabilitation and behavior therapies (e.g., PSR, DBT) combine two separate activities: skills training and individual

therapy. FAR extends behavioral influence beyond the therapy hour (i.e., beyond interventions such as skills group and individual therapy) to the broader social context of the treatment milieu. Rather than being a therapy approach used by individual therapists or case managers, FAR is a therapy approach adopted by all staff in the milieu. Therefore, the treatment environment in FAR performs some of the same functions as the individual psychotherapist does in FAP.

FAR attempts to address many of the unique factors associated with persons experiencing chronic distress. For example, Docherty and Hebert (1997) found that persons with severe mental illness show poor overall recognition of facial affect. Nonetheless, these same individuals appeared to be highly sensitive to what Docherty and Hebert called "arousing affect" (e.g., fear and anger), despite poor comprehension. This research suggests an association between social cues involving negative affect, increased physiologic arousal and disturbed communication. Thus, individuals with schizophrenia have specific deficits that interfere with the ability to identify the nuances that influence social exchange (Corrigan & Green, 1993).

A behavioral perspective on these findings suggests that due to neurobiological anomalies, individuals with schizophrenia are often insensitive to the subtle *contingencies* that shape social exchange. Holmes and River (in review) suggest that these individuals may lose rules that govern most peoples' social behaviors as a result of a deliteralization of language during acute symptom exacerbation. New rules are learned as a result of direct contact with contingencies associated with sensitivity to social cues (e.g., facial affect expressing fear and/or anger) that elicit increased levels of physiological arousal. Behavior is increasingly governed by escape and avoidance behavior that is reinforced via a reduction in arousal (e.g., disorganized speech in a social context changes the demands in the setting). Schizophrenia is only one of many possible psychiatric conditions that can lead to chronic distress.

Like FAP, FAR attempts to establish a social context with functional similarities to the natural environment. However, most chronically distressed individuals live in environments that inadvertently reinforce their current behavior repertoire (e.g., institutional

behavior). As a result, FAR differs from FAP in that it does not create a functional similarity in the rehabilitation setting to the consumer's current environment. Instead, it creates a context functionally similar to environments in which the consumer hopes to live after successful treatment (e.g., living independently within their community).

FAR suggests specific strategies and provides a context for traditional behavioral interventions for persons experiencing chronic distress. Incentive programming and psychosocial skills training, while not new, are understood within FAR from a contextual perspective. It considers behavioral influence at three levels: Program structure; individual targets; and moment-to-moment interaction. Intervening at all levels of influence increases the potential for significant impact on consumer functioning.

#### **FAR: PROGRAM STRUCTURE**

Program structure provides a context within which effective rehabilitation can occur. As stated earlier, FAR attempts to create a social context that shares functional similarities with environments to which consumers hope to gain access as a result of rehabilitation. Functional similarities among environments means that the eliciting and discriminative stimuli present in one context are also present in a second. Rather than create a treatment environment that mirrors the *physical characteristics* of the neighborhood in which the consumer hopes to live (i.e., stimulus generalization), FAR incorporates many of the *social stimuli* of real world settings. Thus, to the degree that ineffective behaviors are present, a functionally similar environment is created in the treatment milieu. The goal is to influence the consumer at the three levels outlined above in order to shape behaviors toward increasing approximations of effectiveness. With a functionally similar treatment setting, generalization of skills is enhanced since they are learned in the context of relevant eliciting and discriminative stimuli. Therefore, unstructured social interaction in the treatment context is as important as formal skills training. Consumers acquire skills via their group participation and then contextualize (act-in-context) their use in the milieu.

The social institutions in which persons with chronic distress live share few characteristics with those of the average citizen

in a western industrialized society. Ordinarily, an individual's social contexts take the form of an interpersonal hierarchy associated with power, privilege and status. Inherent in these hierarchies is a set of rules that govern how individuals within the system improve their position vis-à-vis these three factors. Behavioral norms exist that specify how one interacts with peers, with those more advanced, and with those below one in the hierarchy. Further, rules exist that govern advancement and demotion within the system (Raven & Rubin, 1983).

Unlike ordinary social contexts, many persons in chronic distress live in a social flatland, devoid of incentives to change. Instead, their behaviors tend to be governed by rules associated with immediate contingencies and with survival in current conditions. There is a lack of natural contingencies for gaining access to increasing levels of freedom and independent living.

As noted above, FAR attempts to create a context within which interventions at other levels of influence may effectively promote change by using a level system and incentive program. The program structure of FAR makes explicit in the treatment community what is understood implicitly in ordinary social settings, specifically, the complex relationship between behavioral expectations, privileges, status, and accountability.

For example, at the Trinity Services Inc., Emotion Management Program (TSI-EMP), the social hierarchy and individual movement within it are based on three factors: 1) increasing levels of sophistication in a consumer's ability to effectively interact with peers and staff; 2) increasing responsibility for his own recovery program; and 3) increasing commitment and contribution to the treatment community. Behaviors at each level are progressively complex and demanding. Thus, as an individual moves up the level system, he gains access to an increasing number of privileges, status positions within the milieu, and responsibilities for maintaining the social fabric of the treatment community. By making the social hierarchy explicit, the level system exposes consumers to rules similar to those that govern general social discourse. Feelings of optimism as well as increasing levels of competence are frequently reported by consumers as they acquire new skills and assume new roles within the program. Over

time, the natural contingencies associated with gaining access to privileges, status, and responsibilities increasingly govern consumers' behavior.

The level system shapes the focus of both consumers and staff. Rather than focusing on problems or ineffective behaviors, staff and consumer collaborate in efforts to increase social effectiveness. In rehabilitation programs where a well-defined social structure is lacking, staff may increase their focus on ineffective behaviors. In these settings, they may be experienced by consumers as behavioral "cops." Attempts to decrease ineffective behaviors via aversive interactions foster an adversarial relationship between consumers and staff. As a result, an environment is created that tends to recapitulate innumerable past invalidating experiences for consumers.

As stated earlier, individuals with chronic distress decrease their level of social contact due to aversive interactions experienced in many social contexts. Frequently, these aversive contingencies are of sufficient strength to negate the influence of naturally occurring incentives in the treatment milieu. FAR uses artificial reinforcers to shape increasingly accurate approximations of effective social behavior. These incentives support behaviors that otherwise might be extinguished due to a lack of reinforcement. By increasing the density of the positive reinforcement associated with target behaviors, behavioral momentum is created which keeps consumers actively engaging in socially effective behavior. With time, consumer behaviors are maintained less by artificial reinforcers as these behaviors are naturally reinforced by the consequences of successful social behavior.

For example, most program participants at the TSI-EMP receive social security disability payments and live in residential facilities. Typically, residential programs provide a minimal amount of money to consumers each month for their own consumption (e.g. \$30.00). Many consumers spend these funds on sundries such as cigarettes. Unlike the average citizen, consumers do not have the funds to shop at places like K-Mart for shampoo, tooth brushes, toothpaste, hand lotion, bracelets, walkman, baseball caps, etc. The only viable economy in which they can participate is the Program's. Thus, although many consumers who enter the

program have little interest in learning illness management or interpersonal effectiveness skills, they attend and participate in psychoeducational groups in order to earn points with which to purchase items from the Program's store.

Usually, if a consumer remains in the program for six to eight weeks, he will stay for the remainder of his treatment (depending upon treatment goals, length of stay may range from 12 to 32 weeks; Corrigan, 1993). The incentive program not only meets the basic needs and wants of consumers but also keeps them in contact with didactic material about illness management and other skills via group involvement. In the process, they both observe their peers and experience for themselves the natural contingencies associated with illness management and relationship effectiveness. Therefore, incentive programming creates behavioral momentum for the effective social behaviors of consumers who participate in the social hierarchy of the milieu. This eventually leads to social behavior under the control of an ever-expanding number of rules. Rule-governance of social behavior fosters a decreased sensitivity to contingencies in the moment and may lower a consumer's vulnerability to arousing emotions and symptom exacerbation in natural settings.

The discussion thus far suggests that program structure creates a behavioral frame or context within which to address consumer behaviors that interfere with social effectiveness. This structure provides the "if...then" for the relationship between increasingly complex social behavior and access to privileges. The step-wise organization of the social context maximizes participants' opportunities for success as they develop increasingly sophisticated social behavior. The incentive program keeps participants in contact with training opportunities until their skillfulness becomes intrinsically rewarding. As a result behavioral momentum is generated and leads to increasingly sophisticated, rule-governed social behavior (Plaud, 1997).

## **FAR: TARGETING INTERPERSONAL BEHAVIORS**

### **Contextualizing Current Coping**

Within the context set by the program structure (e.g., level system, incentive program),

a hierarchy of clinically relevant behaviors guides staff-consumer interaction in the various settings in the program (i.e., individual session, skills group or unstructured milieu interaction). Targets are purposefully vague and are designed to direct staff to classes of behavior, providing a guide for responding based on consumer behaviors in the moment. Targets are organized hierarchically in terms of their priority in the milieu:

- 1) Physical Aggression
- 2) Self-harm
- 3) Emotional/Physiological Arousal
- 4) Experiential/Emotional Avoidance

### **Physical Aggression**

Maintaining a safe treatment environment for consumers and staff is a basic necessity to learning new skills. Physical aggression toward others, property or self can have a detrimental impact on the rehabilitation environment. Structuring the program in a way that takes into consideration factors associated with the potential for aggression may reduce the number of these incidents. Further, having staff actively involved in the milieu and monitoring pre-aggressive behaviors can set the occasion for applying alternative skills in response to factors that in the past may have resulted in aggression.

There are a number of factors that lead to physical aggression in the rehabilitation context. Programs that are structured to clarify staff and consumer roles and to clearly outline the means for obtaining desired outcomes report fewer incidence of aggression (Corrigan, et al., 1994). Often a combination of proactive and reactive interventions can significantly reduce aggressive behavior. For example, de-escalation strategies such as removing the target of aggression (e.g., removing John when Joe is "going off" on him), reducing stimuli in the immediate area (e.g., turn lights out, relocate other consumers) and focusing on the function of current behavior rather than the content of consumer verbalization are several strategies used to manage physical aggression in the milieu.

Frequently, consumers are inadvertently reinforced for using intimidation and/or outright physical aggression to escape aversive private experiences such as frustration and anger.

Typically, these types of behaviors change the social context (e.g., lower the demands made of the consumer) in which the intense emotion is experienced thereby changing the emotion itself.

FAR staff's first priority is maintenance of the treatment milieu. Therefore, a combination of proactive and reactive interventions is used to decrease the probability of incidents of aggression and/or reduce the duration, intensity and the destructive impact should they occur. Emphasis is placed on identifying contextual factors associated with potential for aggressive behaviors. Often aversive private experiences are poorly tolerated and lead to aggression. Keeping distressed consumers in contact with factors that evoke these bodily states enables them to apply skills learned in the skills group. Rather than focusing on changing the consumers private experience (e.g., frustration and anger), staff work to teach the consumer how to be mindful of contextual factors associated with intense emotion, minimize emotional avoidance and apply effective emotion regulation skills (Linehan, 1993).

### **Self-harm**

Self-harm is considered any behavior undertaken by a consumer in which the intent is to inflict bodily harm and/or death. This class of behavior can be difficult to extinguish. Self-injurious behaviors are powerfully reinforced due to the avoidance of aversive private experience (e.g., guilt, self-loathing). Frequently, consumers who engage in this type of behavior have a learning history that is replete with reinforcement for emotional avoidance. These consumers are unable to self-tact emotion but are acutely aware of action-urges to self-injure.

Staff members distinguish between self-injurious behavior elicited by current contextual factors (respondent behavior) and those maintained by changes in the interpersonal context in response to the behavior (operant behavior). In the former, staff members provide support, validate current action-urges and coach consumers to apply new skills while in contact with aversive states. When self-injury is an operant, staff therapists curtail reinforcing contextual consequences and focus on teaching the consumer how to make requests effectively and to observe limits. Physical aggression and self-injury are considered only two examples of

a class of behaviors that are functionally defined in terms of how well they enable the individual to avoid aversive private experiences.

### **Emotional/Physiological Arousal**

Many consumers titrate their exposure to interpersonal contexts that bring them in contact with controlling variables or cues that elicit aversive private experiences. Often, social isolation has become a perpetuating factor in a consumer's chronic psychological distress. The functional similarity of the treatment context with typical social settings exposes consumers to cues that are frequently avoided. Contact with these cues in the milieu can set the occasion for intense emotions. Staff members are present in the milieu in order to maintain a safe environment within which to learn emotion regulation skills (Linehan, 1993).

When consumers are in contact with relevant controlling variables, staff interact with them in order to provide accurate validation of emotional reactions. Validation enhances consumers' ability to remain in the present context without having to engage in emotional avoidance. As a result, consumers habituate to intense emotion and learn more experientially effective behaviors in the presence of previously avoided cues. They learn to experience their emotional responses as important sources of validation, motivation and communication (Linehan, 1993). The goal of staff interaction is to set occasions for and reinforce effective emotional responding by consumers within the social context of the program.

### **Experiential/Emotional Avoidance**

Avoidance of cues that elicit emotion is a common practice of persons experiencing chronic distress. Any behavior can serve as a means to avoid such cues; examples include breaking eye contact, changing a topic of discussion, sudden withdrawal from a conversation or leaving the group (Kohlenberg & Tsai, 1991). The social context of the program both in formal treatment activities (e.g., skills groups and individual psychotherapy) and the unstructured social time between groups increases the probability of contact with eliciting and discriminative stimuli for emotional reacting and/or avoidance.

Group leaders engage consumers in skills group frequently and continually interact with consumers reticent to participate in order to decrease the benefits of not interacting. Further, staff find ways of reinforcing consumer

responses during group activities in order to increase participating behaviors in social contexts – always reinforcing the nugget of effectiveness of all attempts on the part of the consumer to contribute. During unstructured time, staff members remain in the milieu to monitor, initiate and shape interaction with and between consumers. Staff members engage in socially appropriate conversation, but attempts by consumers to discuss personal problems and concerns are redirected to their primary therapist.

An important target in individual psychotherapy is an examination of factors eliciting experiential avoidance in the milieu. Functional analysis of avoidance in the milieu serves to bring the consumer into contact with variables that are associated with avoidance. Together, therapist and consumer schedule planned exposure to cues to aversive private experiences and practice behavioral alternatives to avoidance in-vivo. With an emphasis on targeting avoidance, staff do not inadvertently reinforce avoidance behaviors; they intervene early in behavioral chains that otherwise may lead to more serious and destructive behavior.

When the treatment team is operating effectively, vigilance about and effective responses to consumer emotional dysregulation and experiential avoidance decreases the probability of behavioral responding at the level of physical aggression and/or self-injury. Emphasis is upon effective emotional responding that is, teaching consumers the function of emotion in dealing with conflict and intimate relating. Consumers learn that their emotional responses are not experiences to be changed and/or controlled but an important aspect of effective living.

Hierarchy for staff

At any given moment during the treatment day, various members of the FAR treatment team may be engaged in a variety of treatment activities. While the hierarchy of clinically relevant behaviors organize staff response to consumer behavior, a second hierarchy indicates the priority of clinical activities for staff at any given moment. Engaging in or remaining in a treatment activity is considered only after activities higher in the hierarchy are appropriately staffed and effectively implemented and/or monitored.

- 1) Milieu Management
- 2) Psycho-education

3) Individual Psychotherapy

4) Documentation

The program structure provides a context within which to identify the discriminative, eliciting, and reinforcing stimuli for clinically relevant behavior in the milieu. The hierarchy of relevant behaviors and staff priorities increases the probability of maintaining a safe environment and of creating opportunities for shaping consumer behaviors. Further, this creates behavioral momentum for effective social behavior and increases the probability that newly acquired skills will generalize to natural settings (Plaud, 1998).

#### **FAR: Moment-to-Moment Interaction**

##### **Coordination of Topographical and Functional Skills Training in FAR**

Traditionally, skills training is used to increase consumer skillfulness in a broad spectrum of areas including social interaction and illness management (e.g., Anthony & Liberman, 1992; Bellack & Mueser, 1989). Two types of skills training are outlined in the literature, topographical and functional. Each type of skills training presents barriers to successful learning for persons with severe mental illness. Utilizing only topographical skills training tends to teach skills outside of their relevant context. These skills are not associated with stimuli relevant to the consumer's natural settings. As a result, they frequently do not generalize to real-world experiences (Kendall, 1990). On the other hand, the exclusive use of a functional skills training approach in natural settings for persons with severe mental illness tends to have limited effect. The quantity and aversive quality of their ineffective behaviors result in punishing consequences in social settings. These punishing consequences generalize from specific behaviors to social settings in general. Thus, social contexts are experienced as aversive and persons with severe mental illness learn to avoid them.

FAR utilizes both topographical and functional skills training strategies to promote effective living. Topographical skills training provides consumers with formal instruction in a variety of illness management and social skills. Groups educate consumers to rules that govern behaviors that comprise complex social skills.

Functional skills training is utilized both during structured groups and unstructured time as consumers confront, in the program milieu, situations that are functionally similar to the real world. Consumers are differentially reinforced for successful use of skills in the milieu that were learned in groups. As a result, skills are contextualized via reinforcement during natural interaction in the milieu. In this regard, staff function as discriminative, eliciting and reinforcing stimuli in the milieu. Therefore, their presence during unstructured time in the milieu may be even more important than during formal group training.

#### **FAR -- Application of FAP Principles to the Milieu**

As stated in the introduction, Functional Analytic Psychotherapy (FAP) is a radical behavioral approach that focuses on the in-session behaviors of the consumer and therapist (c.f. Kohlenberg & Tsai, 1991 for a comprehensive outline of FAP principles). In FAP, consumer verbalizations are always considered as potential commentary about ongoing interactions between the two parties in the therapy session. Rather than focusing on the content of verbal behavior, the FAP therapist evaluates it in terms of its function.

For example, a therapist might arrive five minutes late for his appointment with a consumer. Once the session begins, the consumer's first words are a description of his reaction to having to wait for his boss "the other day." The FAP therapist considers the possibility that the therapist's behavior (being late for the therapy appointment) was the stimulus for the description of this particular event and explores with the consumer this hypothesis. In order to diminish experiential avoidance (the systematic avoidance of aversive stimuli), the therapist would present his hypothesis regarding the relationship between the consumer's description of events outside of the session and the therapist's own "late" behavior. This may lead to a direct expression of the consumer's reactions to the therapist's behavior and a discussion of his difficulty expressing anger directly to persons in authority and/or whom he respects.

In milieu-based programs, verbal behavior with suicidal content, threats of aggression, or descriptions of physical pain frequently function to shape staff behavior. Typically, staff respond to the acute crisis,

allowing the consumer to avoid or escape contact with the cues that are eliciting aversive private experiences in the moment (e.g., flashbacks, sadness, boredom). In the context of the program structure and individual consumer targets, FAR focuses on the function of CRBs during both structured groups and unstructured milieu interaction. During moment-to-moment interaction staff respond to ineffective behaviors (CRB1s) in a non-reinforcing manner.

For example, Charlie J. has a habit of interrupting conversations by loudly asking questions about religious topics. In a team meeting, staff agreed to use extinction in order to decrease the frequency of this behavior. Thus, during a break time, John and Jill were discussing how they might arrange the chairs for the next event. In the midst of their conversation, Charlie stepped in and interrupted their dialogue. John and Jill responded by acting "as if" Charlie was not present, continuing to discuss possible options for arranging the chairs. Initially, Charlie increased his interrupting behavior (i.e., extinction burst) and as staff continued to respond to this behavior consistently, it subsided. In fact, Charles began commenting on what was happening (a CRB3), saying, "Come on, you guys! You're ignoring me." Staff examined the costs and benefits of the "interrupting behavior" with Charlie and taught him more effective ways of initiating contact with staff. In the process, Charlie learned both effective engagement and self-monitoring skills.

When a consumer displays effective behavior in situations with stimulus characteristics that in the past were associated with ineffective behavior, staff socially reinforce replacement behaviors. For example, Charlie began asking if he could talk to a staff person or peer before launching into a conversation (a CRB2). Staff reinforced his verbal behavior by acknowledging his request and describing topics of mutual interest. If they were not currently available, staff would arrange a time for a conversation later in the day.

Frequently, consumers with chronic distress are oblivious to the impact of their behavior on people around them. All too often, ineffective behavior is inadvertently reinforced. Staff give the person what he requests in order to quell their own aversive private experiences and to get on to the next task. For example, on one

occasion when Charlie interrupted and Jill did not respond, his speech became louder and more forceful. Rather than continue extinguishing, Jill (who was feeling increasingly uncomfortable) stopped her conversation with another consumer and addressed Charlie's concern. The frequency with which Charlie engaged Jill increased for the rest of the afternoon. Thus, the apparent contingencies associated with Charlie's ineffective behavior (attention from Jill) were more powerful than Jill's unapparent aversive response (Hayes, 1994).

CRBs include verbal behaviors that do not appear to be verbal at all. For example, behaviors (e.g., gestures) that function to influence the environment indirectly through a second person are classified as verbal behavior (Skinner, 1957). Many consumers with severe mental illness do not perceive the more subtle social cues (e.g., gestures, facial expressions) associated with interpersonal contact (Corrigan, 1993). Therefore, FAR-trained staff make the implicit, explicit. That is, staff describe their own unapparent responses to consumer behaviors (responses that most socially effective persons would readily observe) as they occur in moment-to-moment interactions in the milieu.

The case history of Lionel T. illustrates this intervention. Lionel was referred from a local community mental health center (CMHC) to the program for excessive touching of female staff. On his first day in the program, Lionel identified returning to his therapist at the community mental health center as an important goal for him. Nonetheless, he continued his habit of touching female staff, which was identified as a CRB1. Initially, staff attempted to use extinction, but with little impact on his "touching behavior." After consultation, female staff responded to Lionel's "touching behavior" in the following manner. "Lionel, I am committed to helping you return to working with your therapist at the local CMHC, and when you touch me like that, I feel disrespected. When I have this feeling, for the moment I lose interest in working with you. I want to work with you. So let's find a different behavior you can use to get my attention."

The previous statement by the staff person is example of a CRB3. When providing CRB3's,

staff contextualize their reactions in the moment in terms of their relationships with the consumer over time. Initially, staff provide CRB3's. Greater responsibility for stating CRB3s is gradually to the consumer as he becomes more mindful of his behavior in context. Thus, consumers develop the skill to observe inapparent stimuli and response sets and learn rules to govern effective social behavior (Hayes, 1994).

For the sake of simplicity, when interacting with consumers in the milieu or individual session, staff are instructed to ask the following question: "Do I want to see more or less of the behavior I am now in contact with?" Staff attempt to naturally reinforce effective behavior—that is, behavior they want to experience more often. In contrast, they are instructed to extinguish or provide a CRB3 for behavior they wish to experience less often.

FAP suggests that a consumer's expression of emotion and/or attempts to avoid it are indications that cues in the present context have brought the consumer in contact with controlling variables associated with his learning history (Kohlenberg & Tsai, 1991). Attempts to control emotion include changing the subject, becoming thought disordered or avoiding direct discourse about a present interaction.

The distinction between the content and function of verbal behavior is illustrated in the following example. Jeff F. is a 34-year-old Caucasian who was referred to the program because of a thought disorder. During individual sessions, he and his case manager would talk about numerous topics. Staff observed the following pattern on a frequent basis. Jeff conversed in an organized manner about benign topics such as basketball; however, when the topic was changed to one that was emotionally charged, (i.e., a disagreement the night before between him and his mother) Jeff's speech became disorganized. He would make numerous unusual remarks including the following: "the Nazi's are coming," "my toe nails are missing," and "I need to because the wire is loud." Rather than focusing on the content of his verbal behavior, staff assessed its function. Using a CRB3, staff consistently pointed out to Jeff the antecedents to his disorganized speech. By keeping him in contact

with cues that increased arousal (e.g., the discussion of a disagreement with Jeff’s mother), Jeff learned to respond more effectively. Eventually, Jeff was able to remain present with his case manager and with his private feelings during emotionally charged discussions. Interacting in this way changed the control of Jeff’s verbal behavior from contingencies in the moment (e.g., the therapist’s office) to relevant contingencies associated with past attempts to interact effectively with his mother.

Due to the number of consumers in most rehabilitation settings, each staff person typically does not have an intimate knowledge of the relevant CRBs for each consumer.

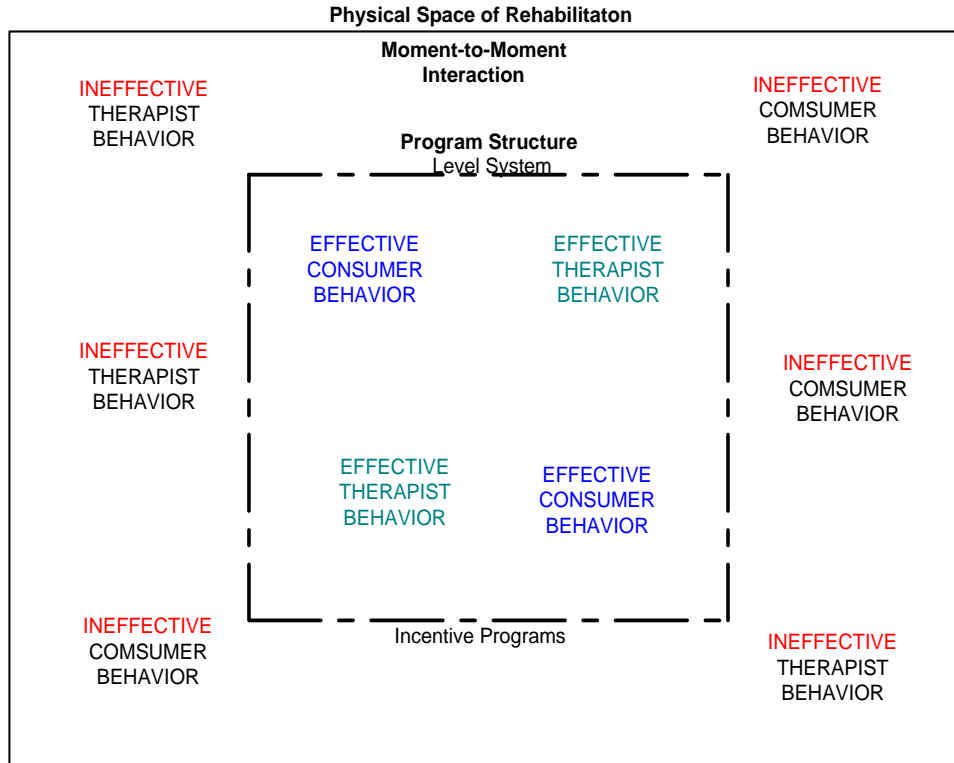
Therefore, staff inform each other of important targets to be mindful of during interpersonal interaction in order to ensure that they do not inadvertently reinforce CRB1s or punish CRB2s. Typically, a target behavior sheet is created for each consumer that focuses on the most relevant CRB1 that occurs in the milieu. The target behavior sheet operationally defines a specific ineffective behavior, a response class of staff behaviors in the presence of a CRB1, a staff-response class with the occurrence of a CRB2, and, when necessary, a description of arbitrary contingencies to be provided to increase the behavioral momentum of CRB2s. Figure 1 is a sample of a target behavior sheet used by FAR staff at the Trinity Services Inc., Emotion Management Program.

Figure 1.

<b>TARGET BEHAVIOR</b>	
Name _____.	Date _____.
<p><b>Target Behaviors</b> (May be an ineffective behavior to be decreased or an effective behavior to be increased. Identify a behavior that can be influenced in the treatment context. Target one behavior per page)</p> <p><b>1.</b></p>	
<p><b>Staff Response to Effective Alternative Behavior</b> (Describe specific effective behaviors that replace/interfere with performance of target behavior and staff [natural reinforcer] response to an occurrence of this behavior)</p>	
<p><b>Staff response to Ineffective Target Behavior</b> (Specify staff response to occurrence of target behavior, e.g. extinction, description of private reactions to behavior.)</p>	

Figure 2

## Differentiating Effective And Ineffective Behavior of the Consumer and Therapist



**Incentive Program** (If applicable, specify formal incentive program for target behavior. Describe the behavior you wish to influence [increase frequency], the arbitrary reinforcers contingent on performance of behavior)

Given the focus on effective and ineffective behaviors, the question often arises as to who decides whether a behavior is effective or not. Recent behavioral therapies have focused on the relationship between the therapist and consumer in the moment and on the differential reinforcement of effective verbal and nonverbal behavior in session (e.g., Dialectical Behavior Therapy and Functional Analytic Psychotherapy). This emphasis has traditionally been the purview of psychoanalytically informed psychotherapies and is discussed in the literature in terms of various topics, including transference, countertransference and projective identification. However, the psychoanalytic literature dedicates significant attention to identifying the ineffective behaviors of the therapist and to the structure of the therapy in order to provide a frame for determining whose ineffective behavior is at issue (Tansey & Burke, 1989; Gill, 1982). For example, Langs (1988) states that maintenance of the therapy frame (e.g., starting and ending the session promptly) is the responsibility of the therapist. When difficulties arise in maintaining the frame, the ineffective behavior of the therapist becomes the focus of therapy. To date, behavioral theorists have not adequately defined strategies for determining whether ineffective interaction in session is a consequence of therapist or consumer behavior.

FAR creates a frame from which both staff and consumer can determine the effectiveness of their behavior in the context of the milieu. As Figure 2 depicts, the program structure (i.e., the level system and the incentive program) defines increasing levels of effectiveness. The level system and incentive program delineate for consumers rules that govern behaviors maintained by social reinforcement (e.g., social status) and rule-governed behavior maintained by reinforcement for rule-following (e.g., arbitrary incentives). These strategies also provide a frame of reference for staff decisions about consumer behavior. Reliance on an operationally defined decision matrix decreases decisions about consumer behavior based on the private experience of individual staff members.

## Summary

Functional Analytic Rehabilitation is a contextual behavioral approach. It creates a context that enhances the impact of traditional curriculum-based interventions such as the UCLA and DBT skills training manuals for persons with chronic distress. These individuals tend to require an intensive rehabilitation experience that optimizes contact with contingencies for each effective behavior. FAR emphasizes the management of contingencies at every level of influence. By increasing the density of reinforcement for effective behaving, the rate of skills acquisition increases. FAR uses a level system and incentive program to create a structure that is the basis for a functionally similar context to real life situations. Individual targets are the basis for collaboration between consumers and staff while moment-to-moment interaction provides in-vivo opportunities for shaping increasingly effective social behavior. By creating an environment with a functional similarity to real-life settings, and a high density of reinforcement for effective responding, FAR provides a context that develops the behavior momentum needed to increase effectiveness and to overcome numerous disincentives to moving toward community integration.

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